Solu-Medrol

RHEUMATOLOGY CONSULTANTS of WNY

WNY Infusion Center

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information

Please check "X" if applicable

PATIENT INFORMATION

Referral Status: _____New Referral _____Updated Order _____Order Renewal

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ____ _____ ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ____ New to therapy ____ Continuing Therapy Last Treatment Date: Next Due date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

PREMEDICATION ORDERS

Premedications not usually indicated.

- ☐ Diphenhydramine ___25mg / ___50mg / ___PO/___IV
- ☐ Acetaminophen ___325mg / ___500mg / ___60mg PO
- ☐ Other:_____

Dose:_____ Route:_____ Frequency:_____

LABORATORY ORDERS

___ CBC ___ at each dose ___every_____

___ CMP ___ at each dose ___every _____

___OTHER _____every_____

___Please "X" if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or Insurance authorization prior to treatment

SPECIAL INSTRUCTIONS

_____

_____

_____

To ensure that a brand name product is dispense, the prescriber must handwrite"Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

THERAPY ADMINISTRATION

–Solu-Medrol Intravenous Infusion
Dose: ___500mg / ___1gram / ___other_____
Frequency: Once Daily x _____doses
Dilute in ___100ml NS / ___250ml NS / ___other_____
If not indicated, doses ≤500mg will be diluted in 100ml and doses >500mg will be diluted in 250ml.
Administer Over: ___30 min / ___1 Hour / ___other_____
If not indicated, doses ≤500mg will be administered over 30 min and >500mg will be administered over 1 hour.

Provider Name (Print)	Provider Signature	Date